Friday, April 28, 2017 **ICLE: State Bar Series**

WORKERS' COMPENSATION FOR THE GENERAL PRACTITIONER

6 CLE Hours, Including

1 Ethics Hour | 1 Professionalism Hour | 3 Trial Practice Hours

Co-Sponsored By:
Workers' Compensation Law Section
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Printed By:

State Bar of Georgia
INSTITUTE OF CONTINUING LEGAL EDUCATION

Publication No.
179602

FOREWORD

Dear ICLE Seminar Attendee,

Thank you for attending this seminar. We are grateful to the Chairperson(s) for organizing this program. Also, we would like to thank the volunteer speakers. Without the untiring dedication and efforts of the Chairperson(s) and speakers, this seminar would not have been possible. Their names are listed on the AGENDA page(s) of this book, and their contributions to the success of this seminar are immeasurable.

We would be remiss if we did not extend a special thanks to each of you who are attending this seminar and for whom the program was planned. All of us at ICLE hope your attendance will be beneficial as well as enjoyable We think that these program materials will provide a great initial resource and reference for you.

If you discover any substantial errors within this volume, please do not hesitate to inform us. Should you have a different legal interpretation/opinion from the speaker's, the appropriate way to address this is by contacting him/her directly.

Your comments and suggestions are always welcome.

Sincerely,
Your ICLE Staff

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Executive Director, State Bar of Georgia

Tangela S. King
Interim Director, ICLE

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Associate Director, ICLE

Sherrie L. Hines
Assistant Director, ICLE

AGENDA

Presiding:
Elizabeth D. Costner, Program Co-Chair, Law Office of Elizabeth DeVaughn Costner, Savannah
Hon. Elizabeth D. Gobeil, Program Co-Chair, Director and Appellate Court Judge, State Board of Workers' Compensation, Atlanta

7:30 **REGISTRATION AND CONTINENTAL BREAKFAST**
(All attendees must check in upon arrival. A jacket or sweater is recommended.)

8:10 **WELCOME AND PROGRAM OVERVIEW**
Elizabeth D. Costner
Elizabeth D. Gobeil

8:15 **"WHAT'S THE BIG PICTURE?" – SYSTEM/PROCESS OVERVIEW & KEY DEADLINES**
Charles E. Harris, IV, Swift, Currie, McGhee & Hiers, LLP, Atlanta
Brian Cunha, Slappey & Sadd LLC, Atlanta

9:00 **"YOU HAVE A CLAIM, SO WHAT'S NEXT?" – PRE-TRIAL & TRIAL PRACTICE 101**
Hon. Andrea R. Mitchell, Administrative Law Judge, State Board of Workers' Compensation, Atlanta
Julie Y. John, Drew Eckl & Farnham, LLP, Atlanta
Stephen H. Brown, Hollington Brown LLP, Augusta

10:15 **BREAK**

10:25 **"NOW THAT DIDN'T GO HOW I WANTED!" – APPEALS 101**
S. Lester Tate, Akin & Tate, P.C., Cartersville
G. Robert "Rob" Ryan, Jr., Ryan Law Firm, LLC, Valdosta

10:55 **"WHAT JUST HAPPENED?" – HOT TOPICS & TRAPS FOR THE UNWARY**
Eric S. Jones, Tavares & Jones, LLC, Atlanta
Jonathan J. Smith, Moore Ingram Johnson & Steele, LLP, Marietta
Hon. David K. Imahara, Chief Administrative Law Judge, State Board of Workers' Compensation, Atlanta

11:45 **LUNCH**

AGENDA

12:10 **"MAYBE IT'S TIME TO RESOLVE THIS CLAIM…" – MEDIATION & SETTLEMENT 101**
Hon. Barbara Lynn Howell, Administrative Law Judge, State Board of Workers' Compensation, Atlanta
Elizabeth D. Costner
Richard S. Thompson, Levy, Thompson, Sibley & Hand, LLC, Albany

1:10 **"SO THE 400 WEEK CAP IS APPROACHING, WHERE DO YOU GO WITH A POTENTIALLY CATASTROPHIC CASE?" – CATASTROPHIC CLAIMS 101**
Deborah Krotenberg, Division Director, Managed Care and Rehabilitation, State Board of Workers' Compensation, Atlanta
Kevin O. Skedsvold, Skedsvold & White, LLC, Atlanta
Shannon Rolen, J. Franklin Burns, P.C., Atlanta

1:50 **BREAK**

2:00 **"HE DID WHAT?!" – PROFESSIONALISM IN HANDLING WORKERS' COMPENSATION CLAIMS**
Harrill "Hal" L. Dawkins, Emeritus Director, State Board of Worker's Compensation, Atlanta
H. Michael Bagley, Drew, Eckl & Farnham, LLP, Atlanta
Ralph R. Lorberbaum, Zipperer, Lorberbaum & Beauvais, PC, Savannah

3:00 **ADJOURN**

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"What's the Big Picture?" – System/Process Overview & Key Deadlines

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GEORGIA WORKERS' COMPENSATION FORMS

FORM	WHEN/WHY FILED	WHERE FILED	SUPPORTING DOCUMENTATION NEEDED
WC-1 **Employer's First Report of Injury**	• Must be filed within **21 days** of employer's knowledge of disability • If controverting, employer/insurer must complete section C within 21 days	SBWC	Potentially a WC-6
WC-2 **Notice of Payment or Suspension of Benefits**	**"Whatever you do, file a 2"** • Filed when commencing, converting, modifying, or suspending benefits	SBWC	• Potential attachments include: full duty release, WC-104 with light duty release, WC-6 • Can potentially be filed simultaneously with WC-240 and attached doctor approved light duty job description or WC-240a
WC-3 **Notice to Controvert**	• File a controvert when any portion of a claim is denied or controverted • Should be filed within **21 days** of notice of disability or request for medical benefits in question • If not timely filed, assessment of attorneys' fees could result	SBWC and any other party with financial interest, including treating physician and attorneys in the claim	Medical records may be attached
WC-4 **Case Progress Report**	• Must be filed annually • Must be filed when case is settled or closed • Basis for form is for Board to be able to monitor claim	SBWC	None
WC-6 **Wage Statement**	• Must be completed when a claimant is entitled to indemnity benefits that are less than maximum allowable rate	SBWC	Potentially filed simultaneously with WC-1 or WC-2
WC-12 **Request for Copy of Board Records**	• Filed when requesting copy of Board records to determine documents filed in current claim or any prior claims • Any party who receives a copy of Board records pursuant to WC-12 shall pay invoice within 30 days of receipt	SBWC (cannot be filed on ICMS)	None
WC-14 **Notice of Claim/Request for Hearing**	• Notice of claim can be filed to toll statute of limitations by claimant • Either party may file to request a hearing on any issue at any juncture of claim	SBWC; all parties to claim	None
WC-25 **Application for Lump Sum/ Advance Payment**	• When benefits have been paid for at least 26 weeks, claimant can request lump sum or advance payment pursuant to this form • Objecting party has 15 days from date of certificate of service to file objection to application for advance	Filed at SBWC by claimant; claimant must send copy to employer/insurer or any other interested party	Objection can be accompanied by supporting documentation
WC-100 **Request for Mediation**	• To be used when party is requesting mediation • Must have agreement of all parties to file	SBWC	None
WC-102 **Request Documents from Parties**	• Mechanism to request documents from parties even when claim not in litigation • Must respond within 30 days of date of certificate of service; subject to penalties for failure to comply	SBWC; opposing party from whom documents sought	None
WC-102b **Notice of Representation**	• Filed by attorney for employer/insurer to indicate representation	SBWC	None
WC-102d **Motion/Objection to Motion**	• Document used to file a motion or objection to motion • Response must be filed within 15 days of the date listed on the certificate of service	SBWC; all parties to claim	Supporting written objection and/or supporting documentation including medical records

WC-104 Notice to Employee of Light Duty Release	• Tendered to notify claimant of light duty work release and potential change in benefits • Sent to claimant by employer/insurer no later than 60 days from the date of a light duty work release • Results in conversion by the authorized treating physician of benefits from TTD to TPD after 52 consecutive or 78 aggregate weeks of light duty releases • Reduces cap from 400 weeks to 350 weeks	Effective January 1, 2014, file with the Board at the same time it is initially served on claimant and claimant's attorney. Attach to WC-2 and file with SBWC and all parties at the time of conversion.	• Medical record reflecting light duty release • Filed simultaneously with WC-2 when converting from TTD to TPD
WC-200a Change of Physician/ Additional Treatment by Consent	• Memorializes mutual consent by the parties to a change in treating physician or agreement to additional treatment	SBWC	None
WC-200b Request/Objection for Change of Physician/ Additional Treatment	• Filed when one party seeks a change in physician • Filed when the opposing party objects to the change in physician request • Must respond within 15 days of the date on the certificate of service	SBWC; all parties to claim	Supporting written objection and/or supporting documentation including medical records
WC-205 Request for Authorization of Treatment or Testing by Authorized Medical Provider	• Form typically sent via fax or email by a medical provider directly to insurer /self-insurer to request specified treatment and/or procedure • Insurer/self-insurer must fax or email response within 5 business days or the treatment or procedure is deemed approved • If denying the requested treatment, a WC-3 controvert must also be filed within 21 days of the date of the WC-205	Neither the request nor the response should be filed with the Board unless otherwise requested	n/a
WC-240 Notice to Employee of Offer of Suitable Employment	• Outlines an offer of suitable light duty employment to an employee on disability benefits (not necessary if they voluntarily return to work) • Follows approval of a light duty job description by the authorized treating physician (Job description must be sent to claimant and claimant's attorney at time it is tendered to the treating physician) • Must be sent to employee at least 10 days prior to return to work date and to attorney if represented • Should include essential duties of job, pay rate, hours/days to be worked, location, and date/time to report to work	WC-2 and WC-240 should be filed with Board when benefits actually suspended; also send to all parties to claim	• Should be sent to the employee with a copy of the job description and a copy of the physician's approval of the light duty job • When suspending, a WC-2 should be filed with the WC-240 and physician's approval of the light duty job attached
WC-240a Job Analysis	• To be completed by an employer providing specific information about a light duty job • Not required, but recommended	SBWC; all parties to claim	Can be attached to a WC-240 job offer
WC-243 Credit	• Employer/insurer is entitled to a dollar for dollar credit for benefits paid unemployment, disability plan, wage continuation plan, or disability insurance. • Must be filed with SBWC no less than 10 days prior to hearing	SBWC; all parties to claim	n/a
WC-R1 Request for Rehabilitation	Employer/insurer shall file in the following instances: • Within 48 hours of catastrophic acceptance designating catastrophic supplier • To request a rehab supplier • To request reopening of rehabilitation • Upon request of the SBWC	SBWC	WC-1 naming catastrophic supplier
WC-R1CATEE Employee Request for Catastrophic Designation	• Form filed by employee when employer/insurer will not voluntarily accept a request for catastrophic designation • Objection must be filed within 15 days of the date listed on the certificate of service	Objection filed with SBWC and all parties to claim	Supporting medical and/or written documentation should be filed with objection

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Summary of Workers' Compensation Provisions

Income Benefits

Temporary Total Disability (TTD) Benefits (O.C.G.A. § 34-9-261)

There is a 7-day "waiting period" before an employee is entitled to income benefits. The employee is entitled to income benefits for the "waiting period" if he or she is disabled for a period of 21 consecutive days.

Effective Date:	**7/1/00**	**7/1/01**	**7/1/03**	**7/1/05**	**7/1/07**	**7/1/13**	**7/1/15**	**7/1/16**
Maximum weekly benefit	$375	$400	$425	$450	$500	$525	$550	$575
Minimum weekly benefit	$37.50	$40	$42.50	$45	$50	$50	$50	$50
Total maximum benefits	$150,000	$160,000	$170,000	$180,000	$200,000	$210,000	$220,000	$230,000

The maximum duration of weekly benefits is 400 weeks from the date of accident except for catastrophic cases, in which there is no cap on income benefits. There is no cap on weekly benefits for accidents occurring before July 1, 1992.

Temporary Partial Disability (TPD) Benefits (O.C.G.A. § 34-9-262)

Calculated by determining the difference between the employee's pre-injury average weekly wage and his post-injury earnings and multiplying that difference by two-thirds.

Effective Date:	**7/1/00**	**7/1/01**	**7/1/03**	**7/1/05**	**7/1/07**	**7/1/13**	**7/1/15**	**7/1/16**
Maximum weekly benefit	$250	$268	$284	$300	$334	$350	$367	$383
Total maximum benefits	$87,500	$93,800	$99,400	$105,000	$116,900	$122,500	$128,450	$134,050

The maximum duration for TPD benefits is 350 weeks. The time period runs from date of accident.

Permanent Partial Disability (PPD) Benefits (O.C.G.A. § 34-9-263)

Permanent partial disability benefits are not due to an injured employee so long as the employee is receiving TTD or TPD benefits. Once the employee's entitlement to TTD or TPD benefits ceases, the employer/insurer have 30 days within which to have the injured employee rated for a permanent partial impairment. The employer/insurer are presumed to have knowledge of the rating not more than 10 days after the date of the report establishing the rating. Once the employer/insurer has knowledge of the rating, it must initiate payment of PPD benefits within 21 days. PPD benefits may be paid in lump sum or weekly and the method of payment is within the discretion of the employer/insurer.

Effective Date:	**7/1/00**	**7/1/01**	**7/1/03**	**7/1/05**	**7/1/07**	**7/1/13**	**7/1/15**	**7/1/16**
Maximum weekly benefit	$375	$400	$425	$450	$500	$525	$550	$575

Maximum weekly benefits for loss of or loss of use of specific members:

Member	**Weeks**
Arm	225
Leg	225
Hand	160
Foot	135
Thumb	60
Index Finger	40
Middle Finger	35
Ring Finger	30

Member	**Weeks**
Little Finger	25
Great toe	30
Other toes	20
Loss of Hearing: One ear	75
Loss of Hearing: Both ears	150
Loss of vision: One eye	150
Body as a whole	300

Death Benefits-Payable only to Dependents (O.C.G.A. § 34-9-265)

Dependents who are wholly dependent upon the deceased employee for income are entitled to 100% benefits. Income benefits to partial dependents are calculated by comparing the deceased employee's average weekly wage to contributions paid by the deceased to the partial dependents.

Effective Date:	**7/1/00**	**7/1/01**	**7/1/03**	**7/1/05**	**7/1/07**	**7/1/13**	**7/1/15**	**7/1/16**
Maximum weekly benefit	$375	$400	$425	$450	$500	$525	$550	$575
Burial Expense	$7,500	$7,500	$7,500	$7,500	$7,500	$7,500	$7,500	$7,500

$230,000 cap for a surviving spouse without dependents within 1 year of death for injuries on or after 7/1/16.

Calculating an Employee's Pre-injury Average Weekly Wage

1. The employee's earnings during the 13 weeks immediately preceding the week of the accident. This method must be utilized first if the employee worked "substantially the whole" of 13 weeks preceding the week of the accident. The 13 weeks of wages are added and then divided by 13.
2. A similarly situated employee. If the employee's AWW cannot be calculated based on the 13 week method, the employer/insurer must take the wages of a similar employee in the same employment who has worked "substantially the whole" of the 13 weeks immediately preceding the injured employee's accident.
3. Contract wage. If neither of the first two methods can be used, the employer/insurer must calculate the employee's AWW by multiplying the hourly rate by the number of hours constituting full-time employment.
4. The computation of an AWW includes hourly pay/salary, tips, food and housing furnished by the employer, bonuses and operational expenses. It does NOT include fringe benefits.

Statute of Limitations and Other Time Limits

1. File initial claim: 1 year from date of injury or last remedial medical treatment, unless statute is tolled.
2. Change in condition: 2 years from the date of last payment of income benefits.
3. Claims for permanent partial disability benefits: 4 years from date of last payment of income benefits.
4. Appeal to Appellate Division: 20 days from date of ALJ Award.
5. Appeal to Superior Court: 20 days from date of Appellate Division Award.
6. Subrogation: If an injured employee does not file suit against a third-party tortfeasor within 1 year, the employer/insurer may file suit and must notify the employee who then has a right to intervene. Employer/insurer's recovery limited by compensation and medical expenses actually paid and only after claimant has been "fully and completely compensated" for economic and non-economic losses. O.C.G.A. § 34-9-11.1. If employee does file suit, protect lien by intervening prior to entry of judgment.
7. Reimbursement: The Board is now empowered to order reimbursement of the overpayment of income benefits to a claimant. The request for reimbursement must be made within 2 years of the date the overpayment was made. O.C.G.A. § 34-9-245.
8. Peer Review: Submit disputed charges to Peer Review within 60 days of receipt.

Notice to Controvert, Payment of Compensation and Awards, Penalties (O.C.G.A. § 34-9-221)

1. The employer/insurer must accept claim or file controvert within 21 days.
2. For accepted claims, employer/insurer must controvert within 81 days.
3. The employer/insurer may controvert a claim based on "newly discovered evidence" at any time. Based on review of certain statutory requirements, it is within the discretion of the Administrative Law Judge to determine what constitutes "newly discovered evidence."
4. If an Award is issued granting income benefits, the employer/insurer has 20 days in which to issue payment (17 days if funds are from outside Georgia). Failure to timely pay subjects the employer/insurer to a 20% penalty. The same rule applies to approved settlements.

Payment of Medical and Other Expenses; Returning Employee to the Doctor/Suspension of Benefits

1. For all injuries occurring on or before June 30, 2013, and for all injuries occurring on or after July 1, 2013, which are designated as catastrophic injuries pursuant to subsection (g) of Code Section 34-9-200.1, the employer shall furnish the employee entitled to benefits under this chapter such medical, surgical, and hospital care and other treatment, items, and services which are prescribed by a licensed physician, including medical and surgical supplies, artificial members, and prosthetic devices and aids damaged or destroyed in a compensable accident, which in the judgment of the State Board of Workers' Compensation shall be reasonably required and appear likely to effect a cure, give relief, or restore the employee to suitable employment.

   For all injuries occurring on or after July 1, 2013, that are not designated as catastrophic injuries pursuant to subsection (g) of Code Section 34-9-200.1, the employer shall, for a maximum period of 400 weeks from the date of injury, furnish the employee entitled to benefits under this chapter such medical, surgical, and hospital care and other treatment, items, and services which are prescribed by a licensed physician, including medical and surgical supplies, artificial members, and prosthetic devices and aids damaged or destroyed in a compensable accident, which in the judgment of the State Board of Workers' Compensation shall be reasonably required and appear likely to effect a cure, give relief, or restore the employee to suitable employment.
2. Properly submitted medical expenses (excluding mileage) must be paid to the provider (or to the employee if paid out of pocket) within 30 days. Failure to pay after 30 days results in a 10% penalty. Failure to pay after 60 days results in a 20% penalty. Failure to pay within 90 days results in a 20% penalty plus interest.
3. O.C.G.A. **§** 34-9-203 was amended, effective July 1, 2013, to require reimbursement for any charges for mileage incurred by the employee be paid within 15 days from the date the employer or insurer receives the charges and reports required by the Board.
4. O.C.G.A. **§** 34-9-203 was amended, effective July 1, 2003, to include penalties for expenses incurred "out of pocket." This section includes employee requests for mileage reimbursements. The employee has 1 year from the date of service to submit a request for reimbursement.
5. O.C.G.A. **§** 34-9-200 was amended, effective July 1, 2003, to make it abundantly clear that an employee receiving compensation has an obligation to submit to examination by the authorized treating physician. If the employee unjustifiably refuses to attend or otherwise obstructs an examination, the Board may order a suspension of benefits.

Change in Condition: Release to Light Duty (O.C.G.A § 34-9-104 (a)(2))

1. Send to employee within 60 days of light duty release by authorized doctor:
   a. Form WC-104
   b. Copy of medical report providing light duty restrictions
2. After 52 consecutive weeks or 78 aggregate weeks of light duty release, to reduce benefits send to employee and State Board:
   a. Form WC-2
   b. Copy of Form WC-104
   c. Copy of medical report

Offering a 240 Light Duty Job (O.C.G.A § 34-9-240, Rule 240)

1. Send to employee at least 10 days before scheduled to return to work
   a. WC-240 (send a copy of job description to employee and their counsel at time description is provided to treating physician)
   b. Description of job, duties, hours, rate of pay
   c. Physician approval (within 60 days)
   d. Location, date, time of job commencement
   e. Attaching a properly completed form WC-240 (a) will satisfy the requirements for making a proper offer of employment.
2. File with Board after refusal to return to work
   a. WC-240 & documents sent to employee
   b. WC-2: suspension of benefits
   c. Statement that employee did not try job
3. Effective, July 1, 2013, employer/insurer must recommence TTD if employee returns to work and attempts the job for eight cumulative hours, or one scheduled workday, whichever is greater, but is unable to work 15 working days; file form WC-2 memorializing recommencement with the State Board. Must also send employee copy of WC-2 reflecting recommencement of benefits. *Failure to immediately reinstate benefits per 240(c) shall result in waiver of employer's defense of suitability of employment for period of time the employer did not pay the weekly income benefits when due.*
4. If the employee fails to attempt the proffered job, the employer/insurer may unilaterally suspend the employee's income benefits.

You Have a Claim, so What Is Next? Pre-Trial and Trial Practice 101

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State Board of Workers' Compensation
Atlanta, Georgia

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YOU HAVE A CLAIM, SO WHAT IS NEXT?

Pre-Trial and Trial Practice 101

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YOU HAVE A CLAIM, SO WHAT IS NEXT?
Pre-Trial and Trial Practice 101

I. Practice Tips from the Attorneys

INITIAL PHONE CALL/MEETING

Whether contacted by the claimant by telephone or in person, the first matter to assess is whether the claimant is represented. If represented, instruct the claimant to speak with their current counsel. If, for whatever reason, the issues with their current counsel cannot be resolved, the claimant must formally terminate the attorney/client relationship in writing before retaining new counsel. If the claimant is not represented, the initial contact should involve an inquiry into the specifics of the claim, including the date and location of the injury, and the employer. Determining the date of the injury involves both the question of proper notice of injury and the applicable statute of limitations.

Notice of the injury must be given to the employer within thirty (30) days of the injury, or within thirty (30) days of the claimant's knowledge that the condition may arise from the work activities. Once notice is given to the employer, the employer will contact its insurer or third-party administrator and complete a WC-1 First Report of Injury. At that time, the adjuster for the employer/insurer may contact the claimant to obtain information about the claim, including taking a recorded statement, and request that the claimant provide a WC-207 Authorization for Release of Medical Records, so the claimant's medical records can be obtained.

The statute of limitations in workers' compensation is either one (1) year or two (2) years, depending upon the circumstances. If the claimant has not received income benefits as a result of the injury, then the statute of limitations is one (1) year from the date of injury, or one (1) year from the last receipt of employer-provided medical treatment, whichever is later. If the claimant has received income benefits, then there is a two (2) year statute of limitations from the last receipt of income benefits.

Once notice of injury and the statute of limitations has been assessed, elicit as much information as possible from the claimant. This includes how the injury occurred, witnesses to the injury, what benefits have been paid (medical or income), and the type and extent of the medical treatment rendered. A client questionnaire is helpful in obtaining the basic information about the claim and the claimant.

During the initial conversation, a basic theory of the claim should be developed. For example, why is the claim either being denied or, at least, why has it not been accepted? Has the claimant been contacted by an adjuster? Has a recorded statement been provided? Does the claimant have contact information for the adjuster or the insurer's claim number? Has a WC-1 First Report of Injury been filed? Have any other Board forms been filed (i.e., WC-2 commencing benefits, or WC-3 Notice to Controvert)? If so, a claim file should exist and the State Board of Workers' Compensation (State Board) will have assigned a claim number.

Not all claims require immediate or direct attorney involvement. If the attorney is contacted by the claimant within a few days of the injury, the claimant may just be asking for basic information about workers' compensation and/or suggestions on how to proceed. Be careful in the early stages because an attorney's direct involvement in an accepted claim can negatively affect the claimant's future employment status. Also, understanding how a claimant's attorney is compensated is important. Generally, fees are recoverable if the attorney's services result in a recovery of income benefit. Also, the claimant must be disabled for a period of seven (7) days before income benefits are payable. So, given the status, it may be best to monitor the claim with or without formally being retained.

EXPEDITED CONFERENCE CALLS

Often the issue presented does not involve income benefits, but some other matter, such as medical benefits. The State Board has an expedited conference call procedure to address issues which may not require a hearing. For example, the claim may have been accepted by the employer/insurer, but the employer/insurer is not authorizing a diagnostic study or procedure. In

this scenario, counsel for the claimant can file a WC-14 Notice of Claim along with the attorney fee contract as a Notice of Representation. The State Board can then be contacted directly and a conference call scheduled with an Administrative Law Judge (ALJ). Although the insurance adjuster can certainly handle the conference call, the employer/insurer may want to retain counsel. Once the employer/insurer retains counsel, that attorney is required to file a WC-102(b) Notice of Representation with the State Board and send a copy to the claimant, if unrepresented, or the claimant's attorney, if represented. Often, issues can be resolved through a conference call without the need for a formal hearing request.

FILING OF THE WC-14

If, after assessment of the facts, it is determined that the claim should be pursued, a WC-14 Notice of Claim/Request for Hearing should be filed with the State Board through ICMS. This requires that the claimant execute a valid attorney fee contract, which is electronically submitted at the time of the filing of the WC-14. If a claim file exists, the fee contract and WC-14 are filed within the existing State Board claim file. If no claim file exists, the filing of the WC-14 initiates the claim.

Naming the correct employer can be difficult at times, because the employer's name provided by the claimant may not be the exact name of the employer listed on ICMS. Check stubs from the claimant can be helpful in ascertaining the correct name of the employer. Additionally, insurance coverage can be verified on the State Board's web site. However, this information does not always line up with the employer/insurer information on ICMS.

The party filing the WC-14 must note on the form whether it is a Notice of Claim or a Request for Hearing. Also, the party filing the WC-14 should identify the nature of the claimant's injuries, including body parts injured, and specify what workers' compensation benefits are being requested. If only a Notice of Claim is filed, the parties cannot engage in discovery. However, the parties can file a WC-102(d) to request certain information on the claim prior to filing a hearing request, such as Board forms, medical information, wage information, etc.

Either party may request a hearing. If a WC-14 is filed to request a hearing, the WC-14 acts as a complaint and, thus, the parties may engage in discovery, pursuant to the Georgia Civil Practice Act. Generally, upon receipt of a WC-14 Request for Hearing filed by the claimant, the employer/insurer will retain counsel, who must file a WC-102(b) Notice of Representation through ICMS and send a copy to the claimant's attorney.

Circumstances may exist where it is not in a party's best interest to immediately file a Request for Hearing. For example, the extent of disability may be unknown as the pertinent medical records have not been received. At times, the claimant can actually obtain copies of the medical records faster than a written request from an attorney. If a Request for Hearing has not been filed, an executed release and letter to the doctor is needed. Have the claimant sign both the WC-207 authorization for release of medical records, as well as a separate release compliant with HIPPA. Many times it is necessary to obtain and review the medical records before filing a Request for Hearing. In claims where disability and/or causation is questionable (i.e., cumulative trauma injuries or pre-existing medical problems), obtaining a narrative report or questionnaire response from the treating physician, before filing the Request for Hearing, can be very helpful. If in doubt on causation or disability, it is often better to spend the money up front and obtain the treating physician's medical opinion before filing the Request for Hearing.

LITIGATION - DISCOVERY/DEPOSITIONS

Once the Request for Hearing is filed with ICMS, the State Board will assign the claim to an ALJ based on the county of injury. The ALJ's office will send out a Notice of Hearing to the claimant, the claimant's attorney, the employer, the insurer, and the employer/insurer's attorney. Subsequent Notices of Hearing will be sent only to the attorneys.

As stated above, once a Request for Hearing is filed, the litigation is subject to the Georgia Civil Practice Act. Interrogatories and Requests for Production of Documents are typically served by the parties. Also, the service of a WC-102 Request for Documents to Parties is recommended, if it has not previously been sent.

A good practice is to calendar three (3) weeks post-filing of the Request for Hearing, and if an attorney for the employer/insurer has not entered an appearance, attempt to communicate with the insurance adjuster to get the claim assigned. Once defense counsel enters an appearance, be sure opposing counsel has a copy of the discovery and work toward the scheduling of the claimant's deposition.

In almost all claims, the claimant's deposition is taken by the employer/insurer's attorney. Depositions should be scheduled after the parties have responded to discovery. Spend the time necessary to adequately prepare the claimant for the deposition. Review the employer/insurer's discovery responses with the claimant, including any incident reports or prior statements. Go over the medical records/opinion of the treating physician and familiarize the claimant with the dates of treatment. Be mindful of the personnel file and any post-hire medical questionnaires or prior claims (whether work-related or personal). The claimant's credibility is paramount. Pre-existing conditions or prior claims/accidents should be addressed with the claimant during the deposition preparation. Criminal history, work history, and general medical conditions should also be reviewed. The claimant needs to understand the theory of the claim as well as the likely defenses.

After the claimant's deposition, the attorneys often discuss the need for additional discovery. Depending on the issues in the claim, the claimant's attorney may also want to take the depositions of the employer representative, employer witnesses, and/or the adjuster. Counsel for the employer/insurer should also spend time with the employer witnesses to adequately prepare them for the deposition, including review of the discovery responses, the claimant's deposition testimony, any personnel information that may be relevant, and information about the accident. The adjuster should also be prepared to discuss his or her investigation of the claim at any deposition, including the basis for the decision to deny the claim, in whole or in part. As for the employer witness depositions, attempt to schedule all depositions on the same day to avoid delay and to reduce costs. Remember, expenses of litigation may never be recovered unless the claim settles or expenses are awarded at a hearing.

The parties may also want to take the deposition of a medical provider. Of course, depositions are expensive, particularly the depositions of medical providers. Thus, counsel should consider questionnaires or narrative letters from the treating physician. Remember, the parties are allowed to be present at the depositions. The claimant often needs to hear the doctor's opinion and/or the testimony of their supervisors and co-workers to have a full understanding of the issues.

The employer/insurer may want to schedule an independent medical evaluation (IME) pursuant to O.C.G.A. §34-9-202 and Board Rule 202. The employer/insurer must provide ten (10) days' notice of the date, time, and location of the examination and must send a check to pay the claimant for mileage, to cover the cost of transportation. In a claim where the claimant is receiving temporary total disability (TTD) benefits or temporary partial disability (TPD) benefits, the claimant has a one-time right to an IME with a doctor of the claimant's choice, paid for by the employer/insurer pursuant to the Georgia Fee Schedule.

If, at any point during the initial stages of litigation, medical records are received, the parties should send the records to opposing counsel to assist in moving discovery along.

Finally, during the discovery phase, the possibility of settlement or other resolution of the claim may be addressed. This is a good time to discuss settlement, including the need for mediation, if both the employer/insurer and the claimant are so inclined.

MOTIONS/CONFERENCE CALLS/CONTINUANCES

The Workers' Compensation Act provides several opportunities for either party to file motions either prior to the scheduling of a hearing or after a hearing has been requested. For example, a Motion for Interlocutory Order may be warranted if a claimant's benefits have been improperly suspended. When filing a Motion, prepare a WC-102(d) and attach to the form a written argument and evidence in support of the Motion, such as medical records or an affidavit from the claimant. Another example is a Motion for a Change of Physician. For this Motion, file a WC-

200(a) form and attach a written argument. The opposing party is allowed fifteen (15) days to object to any motion. The ALJ will normally provide a written order on a motion; however, a motion will be denied if the ALJ feels the issue requires a hearing.

An issue may arise during litigation which requires a conference call if the attorneys cannot resolve the matter between themselves. The ALJ has informal procedures for the scheduling of these calls. Generally, the ALJ's assistant will coordinate the call at a time agreeable to all parties. Many of these conference calls involve the issue of hearing continuances. At the time of the call, the ALJ may have little or no background information on the claim. Be prepared to succinctly explain the status of the claim and the issue(s) in dispute.

As for continuances, it is universally understood that hearings do not go forward on the first setting unless unusual circumstances exist. If the claim necessitates a first set hearing, communicate with opposing counsel as soon as possible to explain the situation. More often than not, multiple continuances are agreed to by the parties to complete discovery. If an agreement cannot be reached on continuing a hearing, move quickly to schedule a conference call.

PRE-HEARING/STIPULATIONS/ASSESSMENT OF CLAIM

If the parties are unable to resolve the issues either through settlement or by agreement, the hearing process is very similar to a bench trial. The ALJ expects the parties to exchange exhibits prior to the hearing and to stipulate to as many issues as possible. Be sure that the exhibits are marked and handled to the ALJ's preference. Emailing a copy of the exhibits to opposing counsel several days prior to the hearing is recommended. This practice often lessens evidentiary issues and/or issues involving the admissibility of the evidence. Pre-hearing is the time to address which witnesses will be presented at the hearing.

The ALJ's assistant will often send out an e-mail asking about the number of potential witnesses and how long the parties anticipate the hearing will last. Questions of average weekly

wage/compensation rate are typically agreed to prior to the hearing unless, of course, that is a central issue to the claim. Date of injury, venue/jurisdiction, insurance, and employment status should be discussed with opposing counsel in advance of the hearing, as should the issue of which party carries the burden of proof. Depending on the facts, the burden may shift, particularly if an affirmative defense is raised. Understanding the burden of proof is an essential element to the theory of the claim.

Most of this is basic trial practice, but, again, understanding the procedures of a workers' compensation hearing and pre-hearing discussions with opposing counsel are vital. Additionally, be sure all witnesses have been properly subpoenaed.

MEDIATION / NEGOTIATION / CONSENT ORDERS

Many issues can be resolved either through negotiation, mediation, or the use of a consent order. If the parties reach an agreement on some or all issues, a consent order is an option. However, not every ALJ will sign a consent order. If you have any questions, contact the ALJ before preparing the proposed order.

Settlement of the entire claim, either through negotiation or mediation, is also an option. Formal mediation can be undertaken by the use of a private mediator or at a State Board-sponsored mediation. To request a mediation at the State Board, either party must file a WC-100 form. Once the WC-100 has been filed through ICMS, the Alternative Dispute Resolution (ADR) Unit at the State Board will send a Notice of Mediation to the parties, setting forth the date, time, and location of the mediation. If the mediation is continued, subsequent notices are sent only to the attorneys. Employer/Insurers often, if not always, want a written settlement demand from the claimant before entering into negotiations or attending mediation.

Evaluating and explaining the negotiation/mediation process to the claimant is a key to a successful resolution. Workers' compensation claims are not personal injury claims. The injured working is not compensated for pain and suffering. The value of the claim is based upon

the future exposure for income benefits and medical benefits, as well as permanent partial disability (PPD) benefits. Claimants often experience difficulties with this concept. Counsel for the claimant must manage expectations. This is often best accomplished by fully explaining the evaluation process and the range of settlement anticipated.

Once a settlement is reached, the process forward also should be explained to the claimant. Counsel for the employer/insurer will prepare the settlement documents. The settlement documents come in two (2) forms – a Bona Fide Dispute Stipulation or a No-Liability Stipulation. If the claimant is receiving or has received income benefits, a Bona Fide Dispute Stipulation will be used. If the claimant has not received income benefits, then the No-Liability Stipulation will be used. No-Liability Stipulations will have language confirming the injury as non-compensable or otherwise denying the injury all together. This language can be upsetting to the claimant. Subrogation (health insurance), Medicare/Medicaid, Social Security Disability, and the need for future medical treatment must be discussed with the claimant and addressed within the settlement documents.

The settlement documents also typically include releases and a voluntary resignation. Again, the claimant needs to be prepared for the fact that most settled claims involve a general release and resignation. In reviewing the settlement documents with the claimant, anticipate questions about other claims that are being released, including questions about unemployment benefits, health insurance, pensions, or 401(k) plans. How outstanding medical bills are to be paid should also be discussed with the claimant if the bills are not covered by the employer/insurer per the settlement document.

If the settlement documents are correct, they are signed by the claimant and counsel and emailed back to defense counsel with the originals being sent by U.S. Mail. Defense counsel will then file the signed stipulation, along with the appropriate State Board forms and medical records, through ICMS. Monitor the time between execution and the filing of the documents by defense counsel through ICMS. The attorneys will be notified by the State Board by email when the settlement documents have been filed and when the settlement is approved. If the claimant is

receiving income benefits and medical benefits, these benefits will be payable and continue through the day prior to approval of the settlement by the State Board.

Be mindful of an underpayment or overpayment of income benefits. The claimant should keep all income benefit check stubs to assure full payment of all benefits due. Normally, the settlement documents address reimbursement if an overpayment arises. The employer/insurer are required to mail the settlement checks within twenty (20) days of the approval of the settlement by the State Board. If the checks are mailed from out-of-state, the checks must be mailed within seventeen (17) days of approval. If the settlement checks are not timely mailed, a late payment penalty of twenty percent (20%) may be assessed.

HEARINGS

A workers' compensation hearing is an administrative proceeding before an ALJ and will be conducted much like a non-jury trial. Either party can request a hearing. At the hearing, the parties will present testimony from witnesses and will enter into evidence relevant and admissible documents, including medical records. The Georgia Rules of Evidence apply to all workers' compensation hearings. Prior to beginning the hearing, the parties will advise the ALJ of the issues, as set forth in the WC-14 filed. The ALJ then confirms which party has the burden of proof, depending on the issues.

If counsel for the claimant has requested assessed attorney's fees, counsel must be prepared to testify as to the claim for attorney fees and expenses of litigation. Attorney's fees are recoverable on an assessed basis if the ALJ determines that the defense was unreasonable, in whole or in part. Expenses of litigation are recoverable if the ALJ determines O.C.G.A. §34-9-221 has been violated, without reasonable grounds. All claimants' attorneys should familiarize themselves with both O.C.G.A. §34-9-108 and O.C.G.A. §34-9-221 if seeking fees and expenses at a hearing.

Attorney's fees are payable either on a *quantum meruit* basis or at 25% of the income benefits payable to the claimant. If an attorney is seeking a 25% contingency fee, the amount received is deducted from the claimant's benefits unless fees are assessed under O.C.G.A. §34-9-108. If seeking *quantum meruit* fees, counsel must testify to the reasonableness of the requested fees, including the hours worked and the hourly rate. Also, cross-examination is permitted. A copy of the requested expenses should be marked as an exhibit and a brief explanation of the expenses given during the attorney's testimony. A copy of the attorney fee contract should also be entered as an exhibit so the ALJ can approve the contract in the award.

Counsel for the employer/insurer may also request assessed attorney's fees and expenses for frivolous litigation. Of course, counsel for the employer/insurer must also be prepared to provide evidence of attorney's fees incurred in litigation.

POST-HEARING BRIEFS

The ALJ will not rule from the bench. Thus, in almost every circumstance, post-hearing briefs are filed by the parties. The ALJ will discuss the filing of post-hearing briefs. Some ALJs will provide a specific due date for the briefs and others will advise that the briefs are due ten (10) days from the State Board's receipt of the hearing transcript. Be sure that the process for notification of the State Board's receipt of the hearing transcript is understood. Typically, the ALJ's assistant will send out an e-mail confirming receipt of the transcript and the due date of the briefs, but this does not always occur. Most ALJs will grant an extension on the due date as long as the parties are in agreement.

No specific format is designated by the State Board for the post-hearing briefs. However, it is best to succinctly state the issues at the beginning of the brief, along with any stipulations, judicial notices, and the burden of proof. A Statement of Facts along with an Argument section is generally the preferred format. Cite to the record in both the Statement of Facts and in the Argument section, along with cites to the applicable case law and/or statutes. If representing the claimant, list in the conclusion of the brief the exact relief sought. The post-hearing brief must

be filed timely through ICMS with a copy forwarded to opposing counsel. A courtesy copy can be e-mailed to the ALJ through their assistant.

II. Practice Tips from the Administrative Law Judge

CONTACT THE BOARD REGARDING THE STATUS OF YOUR HEARING

The parties are required to contact the Board by no later than 2:00 p.m. the day before the hearing if a case needs to be continued or taken off the calendar. That said, the parties are encouraged to figure out the status of upcoming hearings as early as possible. Many ALJs in the Atlanta Metro area have as many as 60 cases -- if not more -- on a calendar, which could mean talking to or corresponding with as many as 120 attorneys, which makes for a very busy day if everyone waits until the day before the hearing to contact the Board.

As a courtesy, assistants can send an email to the attorneys a day or two before the hearing to get a status update but, ultimately, it is the parties' obligation to contact the Board. Failure to do so can result in the hearing being taken off the calendar, not to be rescheduled until a hearing request is re-filed, civil penalties and/or court costs. If a case is to be continued by agreement, a phone call or email is sufficient. If there is an objection to a continuance, the attorneys must make themselves available for a conference call with the Judge.

If the case will go forward, the attorneys will be asked to provide an estimate of the length of the hearing and how many witnesses will be called. The estimate is for the entire hearing, not just one side, and should include not only presenting your case, but also cross-examining your opponent's witnesses and any evidentiary issues that were not handled before the hearing.

On the day of the hearing, if more than one case is going forward, the Judge will ask the attorneys to announce their estimate of the length of the case and usually, the shortest case will be heard first. If you underestimate the time, the Judge can suspend your hearing, take the next case on the calendar and push you to the back of the line.

BEFORE YOU GO ON THE RECORD

Since hearing issues are set forth on forms, often times, the Judge will not know exactly what a case is about until the parties appear at the hearing. So, be prepared for the Judge to ask you some questions about the case before you go on the record. You should be ready to tell the Judge what your client is seeking (e.g., indemnity benefits from Jan.1 through June 1, medical treatment, assessed attorney's fees) and be as specific as possible. For example, you should know the timeframe for which indemnity benefits are sought. If your client's case has been controverted and you are seeking medical treatment, be prepared to tell the Judge who you want designated as the authorized treating physician. If the issue is the Claimant's request for a change of physicians, defense counsel should also be ready to provide the court with the name(s) of the doctor they would like designated because ALJs have broad discretion with regard to medical treatment and medical providers.

Each side should also be able to provide a succinct statement of the issues. This does not mean providing a history of the case — this means stating the issues. For example, "The claimant contends that she injured her neck in an accident arising out of and in the course of employment on January 1, 2017 and is seeking TTD from January 2, 2017 through the present and continuing, medical treatment, designation of Dr. Jones as the authorized treating physician, assessed attorney's fees for unreasonable defense and litigation costs." or "The claimant contends that her refusal to perform the light duty job was justified." The history of the case or the case's background should come out during the presentation of evidence and your hearing preparation should be so designed. Statements made to the Judge before going on the record -- or even alleged facts stated by the attorneys once on the record -- are not automatically "in evidence" and can only be considered by the Judge if those alleged facts properly come into evidence through testimony, including an attorney stating something in his or her place, and documentary evidence.

Also, be prepared to present your stipulations. There are ten (10) general stipulations: Jurisdiction, Venue, Subject to the Act, Coverage/Insurance, General Employment, Average Weekly Wage, Compensation Rate, Notice, Accident/Injury Arising Out Of And In The Course

Of and Disability Arising Out Of And In The Course Of Employment. The parties can certainly stipulate to any other fact about which there is no dispute. Most importantly, the parties should discuss their stipulations prior to calendar call and be prepared to present the stipulations to the Judge before going on the record.

The parties can also request that the Judge take judicial notice of things and to the extent possible, should be prepared to discuss that prior to going on the record. Most often, in workers' compensation cases, requests for judicial notice deal with Board filings or the lack thereof. In that regard, most, if not all, ALJs will take judicial notice of requested items. However, most ALJs will not take judicial notice of the entire Board file -- whether that request is made at a hearing or in a motion. Instead, you should be prepared to tell the Judge exactly what it is in the Board file that you want him or her to take judicial notice of. For example, instead of just asking the Judge to take judicial notice of a Board Form WC-2, ask him or her to take judicial notice of the Board Form WC-2, filed on January 1, 2017, on which the employer/insurer controverted the claim in its entirety on the grounds that the injury did not arise out of and in the course of employment. When it comes to Board forms or other documents, it is arguable that the better practice is to simply tender the document into evidence. That way, if the case is appealed, the reviewing court will have the actual document to review.

Also, be prepared to tell the Judge whether there are any evidentiary issues and whether there will be a request to leave the record open, although both will need to be raised again on the record.

ON THE RECORD

After the Judge has a handle on the hearing issues, stipulations and requests for judicial notice, he or she will go on the record and provide a "Statement of the Case," which is a summary of the elements discussed above. Thereafter, the parties will present their evidence.

Known evidentiary issues and requests to leave the record open can be handled prior to the presentation of evidence. While it is the Board's policy to encourage the parties to close the

record at the conclusion of the hearing, under some circumstances and at the Judge's sole discretion, the record can be left open on request. See, Board Rule 102(E)(5). However, you must make that request at the hearing -- even if you have discussed it with the Judge prior to the hearing. Documents submitted after the hearing, either with a brief or to the Judge's office, will usually not be considered, especially if there has not been a previous request to leave the record open or no formal request by motion to re-open the record after the hearing. If you decide to request that the record be re-opened after the hearing, you should notify the Judge's office immediately, but no later than the date upon which the motion is filed.

If there is an evidentiary issue, the resolution of which might be to continue the hearing, that issue should be dealt with via conference call before the hearing and before witnesses are hauled downtown to the State Board. Of course, there are instances when the evidentiary issue does not arise until the day of the hearing, but there are just as many instances where the parties know in advance that there is an evidentiary issue. Keep in mind that exclusion of evidence, especially medical records, is the last resort, so attorneys should not automatically expect that as the resolution when medical records are not exchanged within 10 days of the date of the hearing. Instead, the attorneys should be prepared to either request a continuance prior to appearing in court or be prepared to come up with other ways to resolve that particular evidentiary issue. Also, keep in mind that non-medical documentary evidence is not subject to Board Rule 102 (E)(3)(a), which provides, in part as follows:

"All medical evidence regarding the treatment, testing or evaluation of the claimant for the accident which is the subject of the hearing should be exchanged between the parties as soon as practicable, but no later than ten days prior to the hearing . . . ."

The attorneys should also know who has the burden of proof prior to the hearing and be prepared to announce that or have their arguments ready. In "all-issues" cases, the Claimant bears the burden of proof. The burden of proof in other cases depends on the issue, the claim's posture, etc. Kissiah's Georgia Workers' Compensation Law, Third Edition is an excellent resource for discussions on burden of proof.

Attorneys should also familiarize themselves with O.C.G.A § 34-9-102 and Board Rule 102 prior to trying a workers' compensation case.

EXHIBITS

In addition to a copy of exhibits for use with your witnesses, you should have a complete copy of exhibits for opposing counsel and the Judge. Indeed, the Judge may want to review exhibits while the witness is reviewing them so have enough copies available so that everyone can follow along -- which may mean 4 total copies rather than 3.

Different Judges have different preferences with regard to exhibits. If you have questions about a particular Judge's preference with regard to exhibits, call his or her office. In general, keep these things in mind:

(1) All exhibits should be labeled with party identification, preferably "C" for Claimant and "D" for Defense or Employer/Insurer. "Employee" and "Employer/Insurer" both start with "E" so the letter "E" should not be used. Each page of the exhibits should be labeled with the exhibit number and page number, e.g., Claimant's Exhibit 1, page 1 of 4 or C1, p. 1 of 4. Also, exhibits should be identified by numbers rather than letters, e.g., Claimant's Exhibit 1 rather than Claimant's Exhibit A.

(2) Chronological order is preferred. Records submitted in chronological order more clearly tell the story of the claim's history. Records submitted in reverse chronological order also tell a story, but the story is convoluted and much harder to read.

(3) Include an Exhibit Cover Page

(4) Exhibits are scanned into the claim's electronic file. Therefore, exhibits should be submitted on 8 ½ by 11 sized paper. You can use tabs to separate the documents, but they will be removed prior to being scanned into ICMS. Alternatively, exhibits may be separated with colored sheets

of paper. Also, consider using binder clips or two-prong fasteners rather than staples or paper clips to separate exhibits

(5) To the extent possible, the parties should consolidate all duplicate documentary evidence including, but not limited to, medical records. *See*, Board Rule 102(E)(3)(a).

(6) Only tender medical evidence that is specifically pertinent to the issues. Certification pages, patient information sheets, insurance cards, advance directives, consent forms, EKG results, etc., should not be tendered into evidence. Most ALJs do not need, nor do they want the entire contents of a patient's medical records file. We trust that the attorneys have exchanged medical records timely and if not, the wronged party will certainly let us know. We expect each side to tender the records that help their case and we do not necessarily need to see a medical record upon which the attorneys are not relying or that does not help tell the "story" of the claim's history.

(7) If reimbursement of or payment of medical expenses is an issue, take the time to create a document that lists the provider to be reimbursed (or the Claimant) and the amount of reimbursement you are seeking. Try to refrain from making the Judge perform any calculation or figure out how to read a medical statement or invoice after the hearing. The same goes for litigation costs -- in addition to tendering invoices or other documentation for the recoverable litigation expenses that are specifically set forth in O.C.G.A. § 34-9-108(b)(4), include a document summarizing those costs. Making things as easy for the Judge as possible is much appreciated.

(8) If the presentation of your case includes video footage that you want viewed in court, bring a computer and make sure you have enough copies of the footage for opposing counsel and the Judge.

PREPARE YOUR WITNESSES

While the cost of a deposition transcript may be an expense the claimant has to bear -- unless the Employer/Insurer's defense has been deemed unreasonable and you request litigation costs -- it is well worth the cost of obtaining the transcript and having the deponent review his or her testimony prior to trial. Similarly, defense attorneys should have their clients to review their deposition testimony. If an individual's hearing testimony is different from his or her deposition testimony, you can be sure that the attorney is going to pick that testimony apart in an effort to impeach the witness' credibility. A witness' clearer or more specific recollection at a hearing than at a deposition can also raise an issue as to his or her credibility.

POST-HEARING

Although motions for a directed verdict can be made at the conclusion of the presentation of the evidence, they are rarely granted. Instead, the ALJ needs time to review the documentary evidence, the hearing testimony and the parties' arguments on brief prior to issuing a decision.

Opening and closing statements are not common in workers' compensation, although they may be allowed at the discretion of the ALJ. Instead, the parties make their closing statements by preparing a post-hearing brief. The due date for briefs depends on the Judge. Some set a specific due date that may be two (2) weeks after the hearing transcript is scheduled to be completed and available for purchase. Others give the parties 10 days after the hearing transcript is filed with the Board. The latter method requires the attorneys to contact the Judge's office to confirm the date the hearing transcript is filed with the Board. Whichever method is used, it will be stated on the record and included in the hearing transcript. Some ALJs easily grant extensions to file briefs, and may just ask that the parties get together, agree on an extension date and advise his or her assistant. Others might not grant extensions easily, so if you need an extension and the Judge's policy on extensions has not been stated on the record, contact the Judge's office and be prepared to tell the Judge's assistant how much of an extension you need. Your brief should include cites to the appropriate statutory and/or case law that applies to your issues. As noted

above, evidence not presented at the hearing should not be attached to a brief and if it is, it will likely not be considered unless the Judge has agreed to re-open the record.

O.C.G.A. § 34-9-102(f) provides that an ALJ will issue a decision -- or "determine the questions and issues and file the decision with the record of the hearing" -- within 30 days following the completion of evidence, unless the time for filing the decision is extended by the board. That said, in practice, decisions or Awards are issued within 60 days of the date of the hearing and become final 20 days after issued unless an appeal is filed. ALJ's also have 20 days after issuance to reconsider an Award, but keep in mind that any motions for reconsideration should be filed early enough to allow for the other side to object and for the Judge to review the arguments presented and respond.

You can find all sorts of information, including Board forms and published Awards from ALJs and the Appellate Division at our website, www.sbwc.georgia.gov. Also, if you need help filing forms or have other questions/issues related to online filing or ICMS, please contact our Call Center at 1-800-533-0682 or 404-656-3818.

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"Now That Didn't Go How I Wanted!" – Appeals 101

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“Now That Didn’t Go How I Wanted!” Appeals 101

Workers’ Compensation for the General Practitioner

April 28, 2017

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I. Appeal Procedure in a Georgia Workers' Compensation Case

Appeals are an interesting, challenging, and crucial part of a Georgia workers' compensation case. If a practitioner handles very many workers' compensation claims, sooner or later (probably sooner) he or she will be faced with the likelihood of filing an appeal, at least to the appellate division level. What follows is a basic outline of the various appeal stages available and issues to be aware of at each stage, along with a few practice pointers.

A. Appeal to the appellate division

The first level of appeal in a Georgia workers' compensation case is from the Administrative Law Judge (ALJ) to the State Board of Workers' Compensation appellate division. The Workers' Compensation Act ("the Act") provides that the appellate division "shall have original appellate jurisdiction" in all workers' compensation cases. O.C.G.A. §34-9-103(a).

The appellate division consists of the Chairman and the two other directors of the State Board of Workers' Compensation, appointed by the Governor.

Mechanism and timing for appeal

The mechanism for obtaining review is by filing an "application for review" which must be made within twenty (20) days of issuance of the notice of the award. Id. The time begins to run from the date shown on the notice of the ALJ award. Board Rule 103.

The application for review is filed through the Board's electronic filing system (ICMS). Presumably, by the time a case reaches the appeal stage, the general practitioner would have already obtained a user name and password for utilizing the ICMS system. If not, this should be done immediately. Please note that the application for review is not among the Board's pre-

printed forms. The practitioner will need to develop his or her own form for the application and the enumeration of errors.

An enumeration of errors should be filed along with the application for review. These documents must be served on opposing counsel. Failure to do so may result in dismissal of the appeal. Board Rule 103(b)(1).

There are at least three important deadlines that follow after the filing of the application for review:

Cross-appeal: the appellee may institute a cross-appeal by filing notice within thirty (30) days of the notice of the award. Practically speaking, if the appellant waits until the twentieth day from the notice of the award to file his application for review, then the cross-appellee will only have ten more days in which to file a notice of cross-appeal.

Oral argument: appearance shall be by brief only unless oral argument is timely requested. Oral argument must be requested within ten days from the date of the certificate of service on the application for review. Board Rule 103(b). For the cross-appellee, this means that the request for oral argument is due at the same time as the notice of cross-appeal. For the appellant, although the Rule provides an additional ten days, as a practical matter the request for oral argument is usually filed along with the application for review.

Written briefs: it is extremely important to submit written argument in every workers' compensation appeal. Since oral argument is limited to five minutes per side, most of the arguments on appeal will only be presented in written form.

The appellant has twenty days from the date on the certificate of service on the application for review to file a brief. Interestingly, since the Board's rules otherwise provide for

electronic service, the Rule regarding submission of briefs states that service must be in person or by mail. Board Rule 103(b)(2).

The opposing party has twenty days from the certificate of service shown on appellant's brief to file a reply brief.

Note that the brief should generally follow the format required by the Georgia appeals courts and, importantly, is limited to twenty (20) pages in length. The appellate division has discretion to refuse to consider portions of the briefs exceeding twenty pages, unless permission to exceed the limit has been obtained. Board Rule 103(b)(4).

What is appealable?

The Act states that "a decision" of the ALJ may be appealed to the appellate division. However, it is only a final decision, reduced to terms of an award, that is directly appealable. An interlocutory order, on the other hand, is not allowed unless the ALJ, in the exercise of his discretion, certifies that the order or decision is of such importance to the case that immediate review should be had. In such cases, the application for review must be filed within twenty (20) days of the original interlocutory order (*not* the date of the issuance of the certificate of immediate review). Board Rule 103(d). This interlocutory review procedure seems to be utilized infrequently in workers' compensation cases.

Standard of review

Appeal to the appellate division was *de novo* prior to amendment of the Act effective July 1, 1994. Since that time, review at the appellate division has been subject to a preponderance of the evidence standard.

The appellate division's review standard is found at O.C.G.A. §34-9-103(a): "The findings of fact made by the administrative law judge in the trial division shall be accepted by the appellate division where such findings are supported by a preponderance of the competent and credible evidence contained within the records." However, the statute also provides that the appellate division "shall review the evidence and shall then make an award with findings of fact and conclusions of law." Id.

Although perhaps not at first apparent, the appellate division retains wide latitude under the preponderance standard. The appellate division is entitled to, and in fact is commanded to, review the evidence and make findings of fact and conclusions of law. Often, the appellate division will determine that the ALJ's award is supported by a preponderance of evidence. However, where the appellate division determines otherwise, it remains empowered to vacate the ALJ's findings of fact and conclusions of law and to substitute its own findings of fact and conclusions of law in its place. See, Bankhead Enterprises v. Beavers, 267 Ga. 506 (1997).

In fact, given the "any evidence" standard that applies to appeals at the superior court and higher levels, the appellate division is for practical purposes the *last* opportunity that a practitioner will have to have a court take a new look at the facts of the case and, perhaps, arrive at a different conclusion from the ALJ.

Oral argument

Oral argument is limited to a mere five minutes per party. Board Rule 103(b). A few practice tips:

First, any argument of importance to the case must be set forth in the brief. Practitioners should not assume that they will have the opportunity to make their arguments orally.

Sometimes the appellate division asks few or no questions, and whatever points that are outlined for argument can be reached and made. Other times, one, two, or even all three of the appellate division judges will actively ask questions. Five minutes can easily be taken up by just a few questions, leaving the attorney no time to get to the (no doubt well researched and reasoned) points he or she had prepared for argument.

Second, time may be reserved, and it is often a good idea for the appellant to reserve a minute of time for a brief rebuttal argument.

Third, and of great importance, a decision must be made whether to travel to Atlanta and appear in person or whether to argue by videoconference. The Board's videoconference system has been an extremely positive development for those of us who practice in the far flung reaches of Georgia's 159 counties. Prior to the advent of videoconference arguments, an attorney in Valdosta would have to travel 8 hours roundtrip for a five minute oral argument. The technology employed by the Board works well, both in terms of video and sound quality. For those attorneys who practice well outside the metro area, argument by video conference should be strongly considered as an effective and cost saving method of presenting the case.

On the other hand, there are times when it is good to "show your face" to the judges in person and some cases are of such importance that an argument in person is justified. These are obviously decisions to be made on a case by case basis.

If the videoconference option is chosen, the appellate division clerk (Cathy McNiel) must be timely notified so that the proper arrangements may be made.

Attorneys' fees

Attorneys should be careful to only take positions on appeal that are arguably supported by the facts and the law. In addition to the attorney's ethical obligation (Georgia Rules of Professional Conduct 3.1) the State Board has the power to assess attorneys' fees for a frivolous appeal. See, O.C.G.A. §34-9-108(b)(1); Board Rule 103(f).

B. Appeals to the superior court

Mechanism and timing for appeal

Appeals to the superior court are governed by O.C.G.A. §34-9-105. In general, the issues that can be determined on appeal to the superior court and higher levels are tightly circumscribed by statute. Most workers' compensation cases are therefore won or lost at the ALJ and appellate division levels.

An appeal to the superior court must be taken within twenty (20) days of the date of the award of the appellate division. O.C.G.A. §34-9-105(b). This is accomplished by filing a notice of appeal with the Board stating generally the grounds upon which appeal is sought. Id. The notice of appeal is filed via ICMS.

Once the notice of appeal to the superior court is filed, the Board is required to transmit the notice of appeal and a certified copy of the Board's record to the clerk of superior court within thirty (30) days of the filing of the notice of appeal. O.C.G.A. §34-9-105(b). The appellant is required to pay the copying and transmittal costs. Board Rule 105(f).

The Board will provide notice when it transmits the record to the superior court clerk. Upon receipt of the record, the superior court clerk will docket the case and assign it a superior court case number. Several crucial deadlines are triggered by the date of docketing:

60-day rule: the superior court must hear the case within 60 days of the date of docketing, or set a hearing within 60 days of the date of docketing that it continued to a date certain. If the superior court fails to adhere to this rule, then the Board's decision is affirmed by operation of law. O.C.G.A. §34-9-105(b).

20-day rule: once the hearing is held, the superior court only has 20 days from the date of the hearing to enter an order on the appeal, otherwise, the Board's decision is affirmed by operation of law. Id.

10-day rule: once the case is docketed, either party may bring the case to a hearing by providing ten days' written notice to the other party, or the court may assign a hearing date. Id.

Practice pointers: Attorneys must be proactive in making sure that the superior court clerk and judge act promptly and within the timelines outlined above. The attorney who relies on the clerk and the judge to do this for him may be surprised to find that his appeal is lost and the Board's decision is affirmed by operation of law. The level of familiarity with workers' compensation appeals varies greatly from court to court. It is incumbent upon the attorneys to make sure that the appeal is processed and heard timely.

The Board will notify the attorneys of the date that the file is transmitted to the superior court clerk. Please note that this is *not* the date of docketing. The attorneys should contact the clerk to ensure that the clerk is aware that the appeal is being sent and to ask that the clerk notify

the attorneys of the date of docketing and of the new superior court case number, and follow up if no response is received.

Once the case is docketed, then the appellant attorney should ascertain which superior court judge will hear the appeal and make early contact with the judge's office to schedule a hearing, and to ensure that the hearing is set within 60 days of docketing. Once a hearing date is obtained, clarify whether the attorney should prepare and send out the hearing notice, or whether the judge's office will do so. None of these steps are prescribed by rule or statute; they are matters of accepted practice.

The attorneys should also clarify whether the superior court judge will allow written briefs, and if so, when the court wants briefs to be submitted. Again, there is no rule for this and practice may vary from court to court. Usually, written briefs are helpful to the court and to the parties and are usually filed before the hearing.

Finally, once the hearing has been held, the appellant must be proactive to ensure that the superior court enters an order within 20 days of the hearing. This does not require hounding the judge. A good practice is to bring up the 20-day rule to the court at the close of the hearing. If 15 days have passed without an order being entered, then a respectful letter to the judge's chambers (copied to the other side) with a reminder of the 20 day deadline would certainly be appropriate.

Location of the appeal

The appeal must be heard in the superior court of the county in which the injury occurred.

For out of state injuries, the appeal must be heard in the county in which the original hearing before the ALJ was held.

O.C.G.A. §34-9-105.

Standard of review

The standard of review on appeal to the superior court differs dramatically from the appellate division. On appeal to the superior court (and higher) the "any evidence" rule prevails as to any factual disputes; while issues of law are subject to *de novo* review.

The Act provides that the Board's decision shall, in the absence of fraud, be "conclusive". O.C.G.A. §34-9-105(c).

The "any evidence" rule has been frequently formulated by the Court of Appeals as follows:

"In the absence of legal error, the factual findings of the Board must be affirmed by the superior court and by the Court of Appeals when supported by any evidence in the administrative record. Erroneous applications of law to undisputed facts, as well as decisions based on erroneous theories of law, however, are subject to the de novo standard of review." MARTA v. Thompson, 326 Ga.App. 631 (2014).

The "any evidence" rule is frequently cited by the Court of Appeals and indeed, many if not most workers' compensation appeals at the superior court level and above are decided based on this rule.

Apart from the "any evidence" rule, the specific grounds for setting aside the Board's decision found at O.C.G.A. §34-9-105(c) must also be considered. These are:

(1) the members acted without or in excess of their powers; (2) the decision was procured by fraud; (3) the facts found by the members do not support the decision; (4) there is

not sufficient evidence in the record to warrant the members making the decision; or (5) the decision is contrary to law. These are the *only* grounds upon which a decision of the Board may be set aside on appeal. O.C.G.A. §34-9-105(d).

Attorneys' fees

The Act does not itself contain any provisions related to assessment of attorneys' fees on appeal to the superior court. However, the Court of Appeals has held that the attorneys fee provisions of O.C.G.A. §9-15-14(b) are applicable to workers' compensation appeals to the superior court. Contract Harvesters v. Clark, 211 Ga.App. 297 (1993).

C. Appeals to the higher courts

Court of Appeals

Appeals to the Georgia Court of Appeals may be taken "within the time and in the manner provided by law." O.C.G.A. §34-9-105(e).

There is no right to have an appeal of a workers' compensation case heard by the Georgia Court of Appeals. The last appeal as of right is to the superior court level. The appeal to the Court of Appeals is a discretionary appeal. O.C.G.A. §5-6-35(a)(1). Accordingly, the normal procedures for seeking discretionary review must be followed, starting with the filing of an Application for Discretionary Appeal, within thirty days of entry of the superior court's order (or within thirty days of the date that the Board's decision is affirmed by operation of law).

The appeal procedure for an application for discretionary appeal in a workers' compensation decision thereafter is the same as for any other discretionary appeal, and therefore will not be reviewed in detail here.

Supreme Court

Appeal to the Georgia Supreme Court may be sought by writ of certiorari or application for discretionary appeal. Again, the procedure for workers' compensation appeals is the same as for other cases so appealable, and so will not be discussed at length here.

The "any evidence" standard of review applies equally to the Court of Appeals and the Supreme Court, as to the superior court.

Conclusion

Successful prosecution or defense of an appeal of a workers' compensation case requires diligent attention to the requirements of the Act and the Rules. Please feel free to contact the author with any questions regarding these issues.